Cook County Health: Ambulatory Quality Improvemen

HEDIS Performance Projects Update

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COOK COUNTY HEALTH

HEDIS Metrics

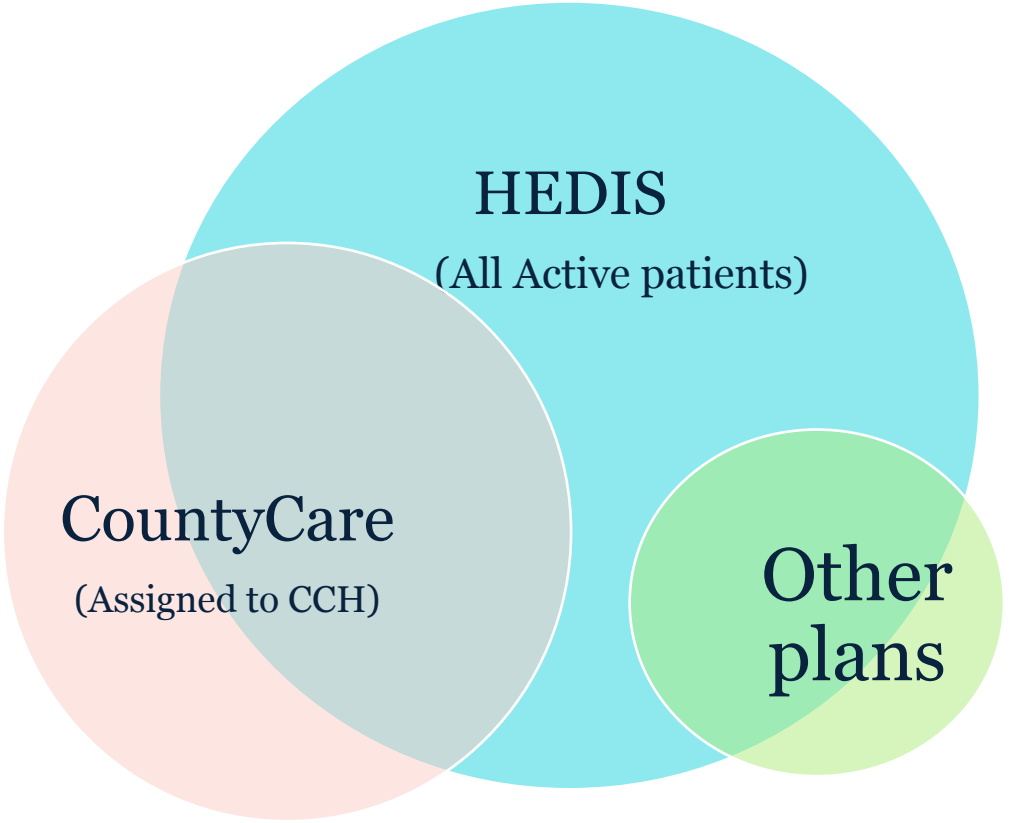
Healthcare Effectiveness Data and Information Set (HEDIS)

- Comprehensive set of standardized performance measures designed to provide purchasers and consumers with the information they need for reliable comparison of health plan performance.
- Widely used performance improvement tools with over 190 million people, enrolled in Medical insurance plans that report **HEDIS** results.
- Relate to many significant public health issues, such as cancer, heart disease, smoking, asthma, diabetes, early detection and prevention
- For our Primary Care settings at CCH
  - Data allow identification of performance gaps and establishment of realistic targets for improvement and to track progress
  - Benchmark data with other providers
  - Opportunity to partner with County Care and other Managed Care Health plans to improve care and capture additional financial incentives for CCH.

Source: NCQA – National Committee on Quality Assurance.

Population Health and HEDIS Measures

Empanelment Denominator – Multiple definitions



Current HEDIS Measure Performance

Top Performing Measures

Breast Cancer Screening (BCS)

Comprehensive Diabetes Care (CDC) – Nephropathy Screening

Comprehensive Diabetes Care (CDC) – HbA1c Testing

Opportunity for Improvement Measures

Comprehensive Diabetes Care (CDC) – Blood Pressure Control (<140/90 mm Hg)

Comprehensive Diabetes Care (CDC) – Eye Exam

Comprehensive Diabetes Care (CDC) – HbA1c Control (<8%)

Childhood Immunizations (CIS)

Well-Child Visits (W15, W34) -15 months & 3-6 years

Proposed Priority HEDIS Measures for 2019

Align with current CCH and CountyCare initiatives

Goal: Exceed 80Th Percentile for the metrics

Childhood Immunization Status (CIS)

Comprehensive Diabetes Care (CDC)

- Blood Pressure Control (<140/90 mm Hg)
- HbA1c Control <8% (CDC – HbA1c <8%)
- Eye Exam (CDC – Eye Exam)
- Nephropathy Screening (CDC – Nephropathy Screen)

Timeliness of Prenatal Care (PPC)

Postpartum Care (PPC)

Well Child Visits in the First 15 Months of Life – 6+ Visits (W15)

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

Adult Hedis Measures- 2019- 12 month look back- IE. April 2019-April 2018												
Clinic	CDC-BP Rate - Feb	April	CDC-Eye Exam Rate- Feb	April	CDC-Nephropathy Screen Rate - Feb	April	CDC-HbA1c Test Rate- Feb	April	CDC-HbA1c Control (<8%) Rate- Feb	April	IET - Initiation of AOD Treatment - Feb	April
Austin (AH)	40%	41%	37%	38%	90%	89%	89%	86%	49%	46%		
Cicero (CH)	44%	42%	47%	46%	90%	88%	92%	91%	43%	42%		
Cottage Grove (CG)	46%	46%	49%	48%	91%	87%	94%	89%	47%	44%		
Englewood (EH)	36%	38%	38%	35%	87%	84%	87%	85%	49%	44%		
Logan Square (LS)	46%	44%	48%	47%	89%	87%	93%	89%	46%	41%		
CORE	59%	59%	27%	26%	79%	77%	90%	87%	54%	51%		
Prieto (PH)	47%	83%	57%	55%	90%	88%	85%	84%	40%	36%		
Sengstacke (SH)	46%	47%	46%	45%	90%	87%	86%	84%	47%	42%		
OFHC (OF)	48%	48%	57%	56%	91%	88%	86%	83%	50%	44%		
Robbins (RH)	43%	45%	56%	54%	89%	86%	90%	87%	50%	45%		
Arlington Heights (AR)	45%	45%	27%	26%	88%	85%	92%	88%	42%	38%		
Woodlawn (WH)	40%	42%	37%	35%	85%	84%	87%	87%	47%	44%		
Stroger Campus	45%	45%	50%	49%	88%	86%	87%	84%	52%	45%		
Near South (NS)	41%	41%	30%	27%	90%	85%	91%	87%	51%	46%		
Morton East (ME)	100%	100%			100%	100%	100%	100%				
CCH Overall	44.80%	44.00%	46.30%	45.40%	88.80%	86.60%	88.00%	85.70%	48.10%	43.30%	UNK	
Target (80th %ile)	74%		66%		93%		92%		57%		48%	

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Source: Business Intelligence HEDIS Reports – 4/2019

Childhood Hedis Measures 2019 - Look back for 12 months- IE. April 2019-April 2018						
Clinic	Childhood Immun Rate- Feb	April	Well-Child Visits 0-15 mos Rate - Feb	April	Well-Child Visits 3-6 yrs Rate- Feb	Well-Child Visits 3-6 yrs Rate- April
Austin (AH)	53%	44%	56%	55%	65%	59%
Cicero (CH)	65%	82%	56%	93%	73%	70%
Cottage Grove (CG)	63%	56%	63%	71%	67%	63%
Englewood (EH)	42%	15%	54%	30%	64%	57%
Logan Square (LS)	73%	44%	67%	83%	74%	73%
CORE		100%		100	73%	55%
Prieto (PH)	73%	90%	71%	100%	65%	67%
Sengstacke (SH)	44%	63%	64%	63%	63%	57%
OFHC (OF)					100%	67%
Robbins (RH)	40%	44%	53%	69%	62%	59%
Arlington Heights (AR)	75%	83%	70%	75%	71%	72%
Woodlawn (WH)			100%		25%	10%
Stroger Campus	67%	60%	88%	74%	74%	75%
Near South (NS)	80%	40%	50%	80%	66%	60%
Morton East (ME)					100%	100%
CCH Overall	**59.90%**	**60.20%**	**64.90%**	**68.20%**	**68.00%**	**64.50%**
CountyCare ACHN Empaneled						
Target (80th %ile)	**77%**		**73%**		**81%**	**81%**

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Source: Business Intelligence HEDIS Reports – 4/2019

Proposed HEDIS Measures by Workgroup

HEDIS measures to target and improve on

Adult Workgroup

- Comprehensive Diabetes Care (CDC)
  - Blood Pressure Control (<140/90 mm Hg)
  - HbA1c Control (<8%)
  - Eye Exam
  - Nephropathy Screening

Pediatric Workgroup

- Childhood Immunization Status (CIS)
- Well-Child Visits
  - First 15 Months of Life – 6+ Visits (W15)
  - Third, Fourth, Fifth and Sixth Years of Life (W34)

Prenatal Workgroup

- Prenatal and Postpartum Care (PPC)- Will be combined with Maternal Child Initiatives

Behavioral Health Workgroup

- Initiation and Engagement of Alcohol and other Drug Abuse Dependence Treatment (IET)- Obtaining Baseline metric

QI Project Charter: Patient Centered Primary Care within High Reliability Organization

Team: HEDIS Primary Care Steering Team

Project Scope: Diabetes Care and Childhood Immunizations HEDIS measures

Quality Domain Work Group Dyad: Mark Loafman MD, MPH Kathy Pavkov, RN

Steering Team: Dr. Loafman, Kathy Pavkov, Dr, Cunill, Dr. Maric, Edie Johns, Kisonah Smith, Kelly Simon, Dr. Perry, Thankamma Kuriakose, Lisa Hobson, Katina Daher, Laurel Chadde, Kathleen Shanahan, Claudia Burchinal

What are we trying to Accomplish?

- **Help improve patient outcomes in areas of significant health disparity: HEDIS metrics.**
- **Capture additional Pay for Performance incentives in areas publicly reported.**
- **Align and build on ongoing improvement efforts already underway, using IHI model.**
- **Standardize, spread the team based care processes that demonstrate value and quality.**

Diabetes Care (DM) and Childhood Immunizations (CIM)

Project Aim Statement

- Improve Primary Care for CCH patients with Diabetes age 18-75 and Children age 0-5.
- Specifically, meet (or exceed) performance targets in all of the DM/CIM identified priority HEDIS measures by December 31, 2019.
- Among the many DM and CIM metrics those highest yield for patients were selected as initial focus areas.

Establish Steering Team	**✓ 3/27/19**
Complete Charter	✓ 4/23/19
Establish Work Groups for CIM and Diabetes	✓ 4/23/19
Monthly Meetings to Review Progress	✓ 5/28/19

Childhood Immunizations

Aim Statement

Our Goal is to improve childhood immunization along with overall well child care, by December 1, 2019.

Target is > 77% - Current overall rate for pediatric patients seen is 60%

Establish Steering Team	**✓ 3/27/19**
Complete Charter	✓ 4/23/19
Establish Work Groups	✓ 4/23/19
PDSA Cycle Draft	✓ 5/28/19
Present to Pilot Sites	✓ 6/14/19
Training / Education	❑ 6/21/19
Go Live Pilot – 2 Sites (Englewood/ Near South)	❑ 6/24/19
Spread to all Sites	❑ 10/31/19

Comprehensive Diabetes Care

Aim for CCH and CountyCare 12/31/2019:

- Improve performance on 4 key DM measures to 80% for CCH and CountyCare Age 18-75
- Successful A1c and nephropathy screening at > 92%
- Patients with A1c < 8 at > 57%
- Patients with BP < 140/90 at >74%
- Retinopathy screening/annual eye exam at > 66%

Establish Steering Team	✓ **3/27/19**
Complete Team Charter	✓ 4/23/19
Establish Work Groups	✓ 4/23/19
PDSA Cycle Draft	✓ 5/28/19
Present to Pilot Sites	✓ 6/14/19
Training / Education	❑ 6/24/19
Go Live Pilot – 1 Site	❑ 7/8/19
Spread Best Practices to all sites	❑ 10/31/19

Comprehensive Diabetes Care – Digital Retinal Camera

Aim

Goal = 66% - CCH Ambulatory Services current annual eye exam rate for patients with DM – 45% - Current

CCH purchased 15 Digital Retinal Cameras currently being deployed in Primary Care Sites.

Anticipated Impact if 66% exams complete by 12/31/19: 600-900 retinal photographs / month; 20-25% with Follow UP to Ophthalmology

Digital Retinal Images sent to Ophthalmology physicians for diagnostic interpretation – referral only if positive.

Establish Steering Team	✓ **3/27/19**
Complete Charter	✓ 1/28/19
Establish Work Groups	✓ 1/28/19
Camera Delivery	✓ 5/2019- warehouse and pilot sites
Workflows, Documentation, Testing	✓ 6/14/19
Training / Education	❑ 6/24/19
Go Live Pilot – 2 Site (CORE, GMC)	❑ 6/24/19
Go Live at additional sites	❑ 10/31/19

Primary Focus Areas for PDSA Cycles

High Yield Goals

- **Outreach** - for patients not in care or not up to date with care
- **Process Improvement** - gaps in care in the care delivery for every patient seen, every time
- **Team Effectiveness**– optimize roles/ responsibilities via appropriate training and support
- **Patient Engagement** - optimize portal usage and use of self-management goals
- **Social determinants** – processes to actively address those needed to improve patient outcomes
- **Data Analytics** - continuous monitoring, sharing and response to performance data for each site
- **Learning Health system** - Continuous learning and use of PDSA into site specific PI activities
- **Data Consistency and Capture** - HEDIS Metrics

HEDIS Childhood Immunizations by 2 years old

Best Practices - PDSA

Pilot Sites

Englewood & Near South Health Centers

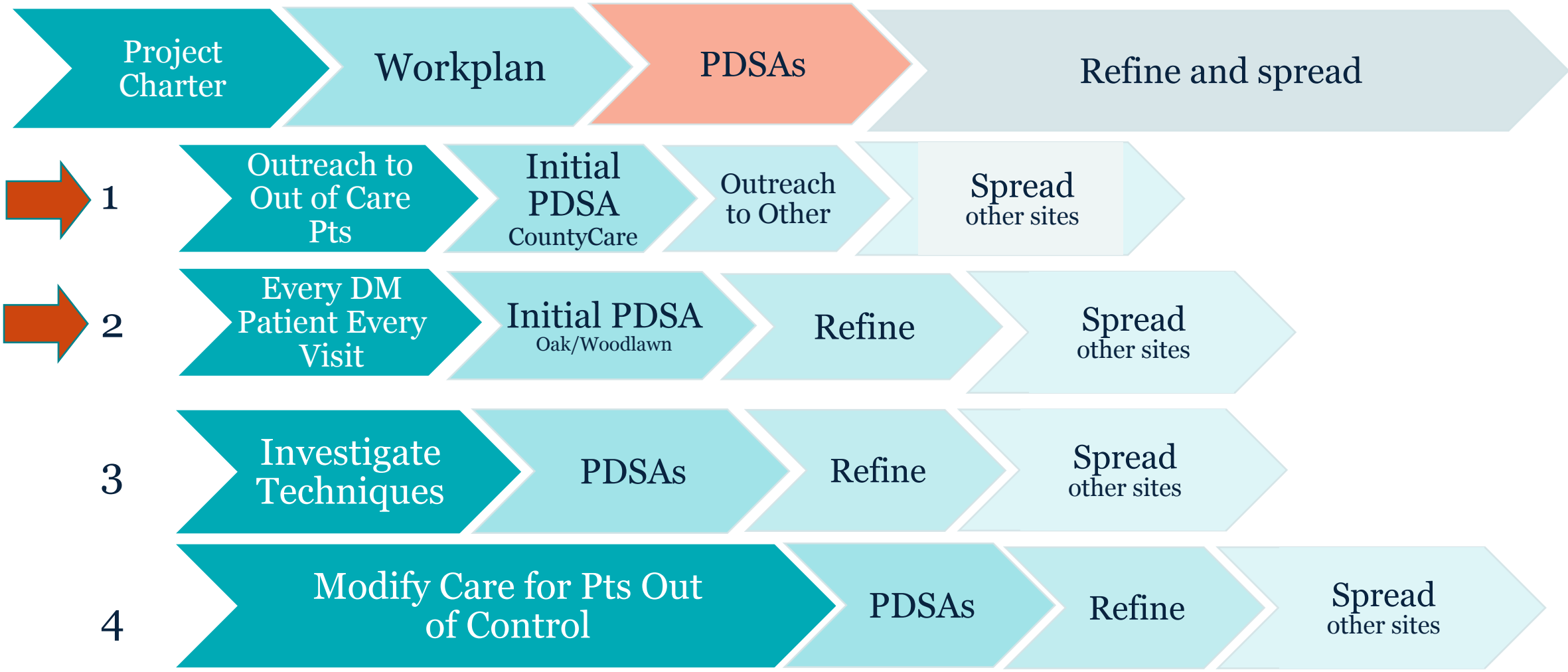
Day of Care/Preplanning (1 -4)

1. Print ICARE out on each patient regardless of visit
2. Import ICARE vaccines into Cerner if found deficient
3. Daily Team Huddle focus on needed Well Child Check-up (WCC) (lead) and vaccines

Outreach (5-7)

5. Automatic reschedule for pediatric No Shows
6. Enroll parent in Patient Portal, send reminders 2 weeks before next appointment.
7. Reach OUT: Clinic manager to provide monthly BI/Pop health patient lists filtered by age to Pediatric Champion & team for assessment of well child care, immunizations, developmental and lead screen

Diabetes comprehensive Care Initiatives*



*In addition to Eye Exams

HEDIS Diabetes Comprehensive Care Initiatives

Best Practices - PDSA

Pilot Sites- Every Patient with Diabetes, Every Time

Oak Forest

Outreach to CountyCare patients in need of care

1. Assigned Staff to perform outreach and make appts

Day of Care/Preplanning

1. Identify Care Gaps – Nephropathy Screen, A1c, Eye Exam, Immunizations
2. Place orders for Gaps
3. Daily Team Huddle focus on patients with Diabetes and needs

Day of Care/ Visit

1. Accurate blood Pressure measurement
2. Health Risk Screen (annually) – Identify Social Determinants
3. Accurate Medication history and adherence
4. Immunizations
5. Self Management Goals
6. Know your Numbers
7. Foot Exam
8. Retinal Photographs
9. Medication reconciliation, adjustments and Refills
10. Referrals and Follow up

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PROVIDER CHAMPIONS

HEALTH INITIATIVES	PROVIDER CHAMPIONS
Access	Mark Loafman MD Yolanda Escalona MD
Diabetes	Nevenka Maric MD
Diabetic Eye	Modupe Oladeinde MD
Behavioral Health Integration	Diane Washington MD
Childhood Immunizations / Well Child Care Visits	Denise Cunill MD, FAAP
E-Consults / Health Education	Titilayo Abiona MD
Hypertension	Arnold Turner MD
Leadership Initiative	Sharon Irons MD
Mammography	Pamela Ganschow MD
Maternal Child Health	Nathalie McCammon-Chase MD Denise Cunill MD, FAAP
Medication Assisted Treatment (MAT)	Juleigh Nowinski-Konchak MD
Men's Health Initiative	Charles Edoigiawerie MD Brian Humphrey PsyD
Primary / Specialty Care Collaboration	Daniel Vittum MD
OPPE Evaluations	Titilayo Abiona MD Norbert DeBiase MD
Sexually Transmitted Diseases (STI)	Chukwuemeka Ezike MD

Thank You

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